Interdisciplinarity defines our identity as medical educators

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Interdisciplinarity defines our identity as medical educators

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Abstract

Medical education is a broad church. As a young interdisciplinary group of educationalists we discuss some aspects of the relevance of interdisciplinarity to medical education, using our own experiences as exemplars.

Keywords: Interdisciplinarity, Medical Education

Challenging a dualist view of medicine

Medical education is a broad church. One of us is a sociologist (MC), one a learning technologist (CT) and two are academic GPs (JJ and HR). As a young interdisciplinary group of educationalists within the social constructionist tradition, our research and teaching work are defined by the broad range of our experience and interests. Here, we discuss some aspects of the relevance of interdisciplinarity to medical education, using our own experiences as exemplars.

Medical students are introduced to the biopsychosocial model of healthcare from first year, yet to a large extent the biomedical model continues to dominate undergraduate medical education. Sociology, and other social science aspects of medicine, have always struggled to establish their identity and relevance to medical students, as they compete with more applied biomedical subjects. The dualist foundations of medicine continue to be a dominant force in undergraduate medical education. What Foucault termed ‘the clinical gaze’ is still highly influential; that is, a highly rational scientific and technological practice (Foucault, 2003). Power is afforded to the clinician and the patient narrative is suppressed in favour of objectively elicited signs of illness. Challenging a dualist, Foucauldian view of medicine, and empowering the patient voice, is a primary concern within our educational practice. For the two clinical academics (HR and JJ), this worldview is deeply in tension with lived experiences of life and work as general practitioners. Such experiences inevitably raise questions about the constructed nature of illness, stigma and healthcare provision, which inform dialogically their medical practice, teaching and research in medical education.

Embodied illness experience and patient voice are powerful teachers, and critical perspectives have much to offer the developing doctor. As a sociologist, MC keeps the patient voice alive in her teaching by exposing students to patient narratives. Individuals living with chronic illness, a rare disease and / or disability are regularly invited to relate their experiences in her lectures. Medical students find these sorts of lectures highly relevant as they relate to the real world (Harden, Kendall and MacBride-Stewart 2016). This lived understanding of illness and life experiences, which have no right or wrong answer but rather multiple shades of grey, introduce students to the inherent uncertainty of medical practice. In a similar vein, near peer learning is used to invite students to lecture on topics that they have a particular interest in or experience of. These include topics such as human trafficking and LGBTQ, subjects in which students are keenly interested and in which the role of healthcare in targeting inequality can be foregrounded. Using students to teach and to develop modules is an underused resource in medical education, and can offer particular powerful learning opportunities.

CT, in her role as learning technologist, follows similar educational principles in fighting against the binaries of technology used in education. Medical education and its research reflect the wider field of tertiary education, in perpetuating two dichotomous messages. The first is that technology is the ‘holy grail’ of all teaching ails and the answer to all data and analytics. The other is the more dystopian view that technology will come to replace teachers and harm student learning. Rather than accepting either of these binary outcomes, CT encourages critical scrutiny of technology use with strong pedagogical underpinnings. The uptake of learning technology is not a

mechanised process operating independently of human control; like other aspects of education, it is a social construction amenable to human agency.

Collectively, we use the dialogue between our different experiences and perspectives to better use the cultural affordances of our complex and ever-changing field. Biomedicine's positivist hegemony is too easily directly translated into medical education. Yet people- patients, families and healthcare professionals- are complex social beings. Interdisciplinarity in medical education has much to offer the developing student in terms of the human experience, but it is not easy. It involves a dynamic process of co-construction, of negotiation with diverse colleagues, of creating useful dialogues which benefit patients and doctors. Together as educationalists we believe our own careers are about lifelong learning, and we have a lot to learn from each other, from our students and patients. As a group, we are all travelling on an epistemological journey. Medical education is a grounded, pragmatic social science. Ultimately our teaching is geared towards improving patient care and patient experience and the work and wellbeing of doctors, and interdisciplinarity is a key route to achieving this goal.

Take Home Messages

Notes On Contributors

M Corrigan is a lecturer.

JL Johnston is a senior lecturer and GP.

H Reid is a GP.

C Thomson is a learning technologist.

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Appendices

Declaration of Interest

The author has declared that there are no conflicts of interest.